

Facility Name & ID Number KENWOOD HEALTHCARE CENTER

0033589 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	128	Skilled (SNF)	128	46,720	1
2		Skilled Pediatric (SNF/PED)			2
3	190	Intermediate (ICF)	190	69,350	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	318	TOTALS	318	116,070	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	9,230	577	2,144	11,951	8
9	SNF/PED					9
10	ICF	80,644	601	102	81,347	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	89,874	1,178	2,246	93,298	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.38%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 04/01/88

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 04/01/88 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 64 and days of care provided 2000

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **KENWOOD HEALTHCARE CENTER** # **0033589** Report Period Beginning: **01/01/01** Ending: **12/31/01**

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	413,474	46,338	5,141	464,953		464,953	(1,019)	463,934			1
2	Food Purchase		436,641		436,641		436,641	(55)	436,586			2
3	Housekeeping	379,369	133,472		512,841		512,841		512,841			3
4	Laundry	147,495	43,985		191,480		191,480		191,480			4
5	Heat and Other Utilities			215,103	215,103		215,103	4,692	219,795			5
6	Maintenance	100,575	123,654	122,118	346,347		346,347	2,199	348,546			6
7	Other (specify):*											7
8	TOTAL General Services	1,040,913	784,090	342,362	2,167,365		2,167,365	5,817	2,173,182			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	2,009,347	26,053	5,631	2,041,031		2,041,031	(8,744)	2,032,287			10
10a	Therapy	52,519		285	52,804		52,804		52,804			10a
11	Activities	102,460	4,493		106,953		106,953		106,953			11
12	Social Services	136,175			136,175		136,175		136,175			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,300,501	30,546	23,916	2,354,963		2,354,963	(8,744)	2,346,219			16
	C. General Administration											
17	Administrative	85,354		480,000	565,354		565,354	40,432	605,786			17
18	Directors Fees											18
19	Professional Services			397,255	397,255	(19,010)	378,245	(358,402)	19,843			19
20	Dues, Fees, Subscriptions & Promotions			39,756	39,756		39,756	(23,539)	16,217			20
21	Clerical & General Office Expenses	771,208	3,446	106,877	881,531		881,531	107,308	988,839			21
22	Employee Benefits & Payroll Taxes			521,754	521,754		521,754		521,754			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,600	2,600		2,600	183	2,783			24
25	Other Admin. Staff Transportation			12,576	12,576		12,576	(2,452)	10,124			25
26	Insurance-Prop.Liab.Malpractice			90,886	90,886		90,886	4,801	95,687			26
27	Other (specify):*							38,303	38,303			27
28	TOTAL General Administration	856,562	3,446	1,651,704	2,511,712	(19,010)	2,492,702	(193,366)	2,299,336			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,197,976	818,082	2,017,982	7,034,040	(19,010)	7,015,030	(196,293)	6,818,737			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			183,497	183,497		183,497	107,749	291,246			30
31	Amortization of Pre-Op. & Org.							9,781	9,781			31
32	Interest			978	978		978	270,543	271,521			32
33	Real Estate Taxes			441,750	441,750	19,010	460,760	7,510	468,270			33
34	Rent-Facility & Grounds			972,066	972,066		972,066	(972,066)				34
35	Rent-Equipment & Vehicles			17,004	17,004		17,004	2,651	19,655			35
36	Other (specify):*											36
37	TOTAL Ownership			1,615,295	1,615,295	19,010	1,634,305	(573,832)	1,060,473			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		71,265	78,053	149,318		149,318	(2,331)	146,987			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			174,105	174,105		174,105		174,105			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		71,265	252,158	323,423		323,423	(2,331)	321,092			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,197,976	889,347	3,885,435	8,972,758		8,972,758	(772,456)	8,200,302			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(174,031)	30		9
10	Interest and Other Investment Income	(44,320)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(55)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(300)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(27,995)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(223,509)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (470,210)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(302,246)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (302,246)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (772,456)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line
			Reference
1	Veterans Expenses-Misc.	\$ (40)	10 1
2	Veterans Expenses-Pharmacy	(8,704)	10 2
3	Legal Expenses	(126,637)	19 3
4	Trust Fees	(100)	21 4
5	Lost Check/Copies	(37)	21 5
6	Contributions Other	(5,548)	20 6
7	Contributions Political	(11,600)	20 7
8	COPE - IL Council Long Term Care	(6,546)	20 8
9	Trust Fees (Building Partnership)	(300)	20 9
10	Accounting Fees (Building Partnership)	(2,025)	19 10
11	Mortgage Insurance (Building Partnership)	4,079	36 11
12	Legal Fees (Building Partnership)	(170)	19 12
13	State Replenishment Tax	(3,463)	21 13
14	Auto Reimbursement Expenses (R.Klein)	(6,168)	25 14
15	Management Fees (Building Partnership)	(56,250)	17 15
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STATE OF ILLINOIS

Summary A

Facility Name & ID Number KENWOOD HEALTHCARE CENTER# 0033589

Report Period Beginning:

01/01/01

Ending:

12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				(1,019)								(1,019)	1
2	Food Purchase	(55)											(55)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			4,692									4,692	5
6	Maintenance			2,199									2,199	6
7	Other (specify):*													7
8	TOTAL General Services	(55)		6,891	(1,019)								5,817	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(8,744)											(8,744)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(8,744)											(8,744)	16
	C. General Administration													
17	Administrative	(56,250)	56,250	40,432									40,432	17
18	Directors Fees													18
19	Professional Services	(128,832)	2,195	(231,765)									(358,402)	19
20	Fees, Subscriptions & Promotions	(23,994)	300	155									(23,539)	20
21	Clerical & General Office Expenses	(31,895)	3,463	135,740									107,308	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			183									183	24
25	Other Admin. Staff Transportation	(6,168)		3,716									(2,452)	25
26	Insurance-Prop.Liab.Malpractice			4,801									4,801	26
27	Other (specify):*			38,303									38,303	27
28	TOTAL General Administration	(247,139)	62,208	(8,435)									(193,366)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(255,938)	62,208	(1,544)	(1,019)								(196,293)	29

Summary B

Facility Name & ID Number	KENWOOD HEALTHCARE CENTER	#	0033589	Report Period Beginning:	01/01/01	Ending:	12/31/01
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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

[illegible]

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ **X** **YES** ☐ **NO**

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	\$ 972,066	KTNC Associates		\$	\$ (972,066)	1
2	V	31	Amortization Expense		KTNC Associates		9,781	9,781	2
3	V	30	Depreciation		KTNC Associates		276,080	276,080	3
4	V	32	Interest Expense		KTNC Associates		308,843	308,843	4
5	V	20	Trust Fee		KTNC Associates		300	300	5
6	V	17	Management Fees		KTNC Associates		56,250	56,250	6
7	V	19	Accounting Fees		KTNC Associates		2,025	2,025	7
8	V	19	Legal Fees		KTNC Associates		170	170	8
9	V	21	State Replacement Tax		KTNC Associates		3,463	3,463	9
10	V	36	Mortgage Insurance		KTNC Associates		(4,079)	(4,079)	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 972,066			\$ 652,833	\$ * (319,233)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	S.W. MANAGEMENT	100.00%	\$ 4,692	\$ 4,692	15
16	V	6	REPAIRS AND MAINT.		S.W. MANAGEMENT	100.00%	2,199	2,199	16
17	V	19	PROFESSIONAL FEES		S.W. MANAGEMENT	100.00%	2,235	2,235	17
18	V	20	FEES, SUBSCRIPTIONS, DUES		S.W. MANAGEMENT	100.00%	155	155	18
19	V	21	CLERICAL AND GENERAL		S.W. MANAGEMENT	100.00%	135,740	135,740	19
20	V	24	EDUCATION AND SEMINARS		S.W. MANAGEMENT	100.00%	183	183	20
21	V	25	TRANSPORTATION		S.W. MANAGEMENT	100.00%	3,716	3,716	21
22	V	26	INSURANCE - PROPERTY		S.W. MANAGEMENT	100.00%	4,801	4,801	22
23	V	27	PAYROLL TAXES		S.W. MANAGEMENT	100.00%	23,683	23,683	23
24	V	30	DEPRECIATION		S.W. MANAGEMENT	100.00%	5,700	5,700	24
25	V	32	INTEREST EXPENSE		S.W. MANAGEMENT	100.00%	6,020	6,020	25
26	V	33	REAL ESTATE TAXES		S.W. MANAGEMENT	100.00%	7,510	7,510	26
27	V	35	AUTO LEASE		S.W. MANAGEMENT	100.00%	2,651	2,651	27
28	V								28
29	V								29
30	V	17	SALARY - SHELDON WOLFE		S.W. MANAGEMENT	100.00%	280,432	280,432	30
31	V	17	SALARY - RONNIE KLEIN		S.W. MANAGEMENT	100.00%	30,000	30,000	31
32	V	27	EMP. BEN.-SHELDON WOLFE		S.W. MANAGEMENT	100.00%	10,442	10,442	32
33	V	27	EMP. BEN.-RONNIE KLEIN		S.W. MANAGEMENT	100.00%	4,178	4,178	33
34	V								34
35	V	17	MANAGEMENT FEES	270,000	S.W. MANAGEMENT	100.00%		(270,000)	35
36	V	19	HOME OFFICE FEES	234,000	S.W. MANAGEMENT	100.00%		(234,000)	36
37	V								37
38	V								38
39	Total			\$ 504,000			\$ 524,337	\$ * 20,337	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SUPPLEMENTS	\$ 10,195	S & E MEDICAL SUPPLY	100.00%	\$ 9,176	\$ (1,019)	15
16	V	39	ANICILLARY EXPENSE	11,657	S & E MEDICAL SUPPLY	100.00%	9,326	(2,331)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 21,852			\$ 18,502	\$ * (3,350)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING & MEDICAL SUPPLY	\$ 18,773	PHARMCOR, L.L.C.	100.00%	\$ 18,773	\$	15
16	V	39	ANICILLARY EXPENSE	53,620	PHARMCOR, L.L.C.	100.00%	53,620		16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 72,393			\$ 72,393	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number KENWOOD HEALTHCARE CENTER # 0033589 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sheldon Wolfe	President	Administrative	29.87%	See Attached	25	41.67%	Sal-SW Mgmt	\$ 280,432	17-7	1
2	Ronnie Klein	Shareholder	Administrative	6.92%	See Attached	30	50.00%	Sal-SW Mgmt	30,000	17-7	2
3	Ronnie Klein	Shareholder	Administrative	6.92%	See Attached	30	50.00%	Mgmt. Fees	210,000	17-3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 520,432		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number KENWOOD HEALTHCARE CENTER # 0033589 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1					\$	\$			1
	2									2
	3									3
	4									4
	5									5
	6									6
	7									7
	8									8
	9									9
	10									10
	11									11
	12									12
	13									13
	14									14
	15									15
	16									16
	17									17
	18									18
	19									19
	20									20
	21									21
	22									22
	23									23
	24									24
	25	TOTALS				\$	\$		\$	25

Facility Name & ID Number KENWOOD HEALTHCARE CENTER# 0033589

Report Period Beginning:

01/01/01Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

S.W. MANAGEMENT

Street Address

7434 N. SKOKIE BLVD.

City / State / Zip Code

SKOKIE, IL. 60077

Phone Number

(847) 982-2300

Fax Number

(847) 982-2304

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIALE BED DAYS	450,410	8	\$ 18,206	\$	116,070	\$ 4,692	1
2	6	REPAIRS AND MAINT.	AVAIALE BED DAYS	450,410	8	8,532		116,070	2,199	2
3	19	PROFESSIONAL FEES	AVAIALE BED DAYS	450,410	8	8,672		116,070	2,235	3
4	20	FEES, SUBSCRIPTIONS, DUES	AVAIALE BED DAYS	450,410	8	603		116,070	155	4
5	21	CLERICAL AND GENERAL	AVAIALE BED DAYS	450,410	8	526,738	470,813	116,070	135,740	5
6	24	EDUCATION AND SEMINARS	AVAIALE BED DAYS	450,410	8	710		116,070	183	6
7	25	TRANSPORTATION	AVAIALE BED DAYS	450,410	8	14,421		116,070	3,716	7
8	26	INSURANCE - PROPERTY	AVAIALE BED DAYS	450,410	8	18,629		116,070	4,801	8
9	27	PAYROLL TAXES	AVAIALE BED DAYS	450,410	8	91,903		116,070	23,683	9
10	30	DEPRECIATION	AVAIALE BED DAYS	450,410	8	22,118		116,070	5,700	10
11	32	INTEREST EXPENSE	AVAIALE BED DAYS	450,410	8	23,361		116,070	6,020	11
12	33	REAL ESTATE TAXES	AVAIALE BED DAYS	450,410	8	29,144		116,070	7,510	12
13	35	AUTO LEASE	AVAIALE BED DAYS	450,410	8	10,285		116,070	2,651	13
14										14
15										15
16	17	SALARY - SHELDON WOLFE	AVG. HOURS WORKED	60	9	673,036	673,036	25	280,432	16
17	17	SALARY - RONNIE KLEIN	AVG. HOURS WORKED	60	7	60,000	60,000	30	30,000	17
18	27	EMP. BEN.-SHELDON WOLFE	AVG. HOURS WORKED	60	9	25,062		25	10,442	18
19	27	EMP. BEN.-RONNIE KLEIN	AVG. HOURS WORKED	60	7	8,356		30	4,178	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,539,776	\$ 1,203,849		\$ 524,337	25

Facility Name & ID Number KENWOOD HEALTHCARE CENTER # 0033589 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization S & E MEDICAL SUPPLY
Street Address 3100 COMMERCIAL AVENUE
City / State / Zip Code NORTHBROOK, ILLINOIS 60062
Phone Number (847) 982-9300
Fax Number (847) 982-2304

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1	DIETARY SUPPLEMENTS	DIRECT ALLOCATION						9,176	1
	2	ANICILLARY EXPENSE	DIRECT ALLOCATION						9,326	2
	3									3
	4									4
	5									5
	6									6
	7									7
	8									8
	9									9
	10									10
	11									11
	12									12
	13									13
	14									14
	15									15
	16									16
	17									17
	18									18
	19									19
	20									20
	21									21
	22									22
	23									23
	24									24
	25	TOTALS				\$	\$		18,502	25

Facility Name & ID Number KENWOOD HEALTHCARE CENTER # 0033589 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization PHARMCOR, L.L.C.
Street Address 3116 S. OAK PARK
City / State / Zip Code BERWYN, IL 60402
Phone Number (708)795-7701
Fax Number ()

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING & MEDICAL SUPPLY	DIRECT ALLOCATION						18,773	1
2	39	ANICILLARY EXPENSE	DIRECT ALLOCATION						53,620	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		72,393	25

Facility Name & ID Number KENWOOD HEALTHCARE CENTER # 0033589 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number KENWOOD HEALTHCARE CENTER # 0033589 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number KENWOOD HEALTHCARE CENTER # 0033589 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number KENWOOD HEALTHCARE CENTER # 0033589 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number KENWOOD HEALTHCARE CENTER # 0033589 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number KENWOOD HEALTHCARE CENTER # 0033589 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	KTNC Associates	X		Mortgage	\$49,744.15	09/23/99	\$ 4,000,000	\$ 3,418,621	09/01/08	8.00%	\$ 308,843	1	
2	Due to Related Entity	x						200,000			978	2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$49,744		\$ 4,000,000	\$ 3,618,621			\$ 309,821	9	
	B. Non-Facility Related*												
10	See Supplemental Schedule											10	
11	Interest Income										(44,320)	11	
12	SW Management Allocation										6,020	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (38,300)	14	
15	TOTALS (line 9+line14)						\$ 4,000,000	\$ 3,618,621			\$ 271,521	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1							\$	\$			\$	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							\$	\$			\$	21

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2000 report.		\$	402,762	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	419,467	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	16,705	3	
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	432,559	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	19,010	5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	468,274	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1996	393,620	8	
		1997	387,490	9	
		1998	386,174	10	
		1999	383,583	11	
		2000	411,957	12	
Line 2 includes SW Management real estate tax allocation of \$7510		13	FROM R. E. TAX STATEMENT FOR 2000 \$	13	
2001 Real Estate Tax Accrual = \$411,957 * 1.05% = \$432,559		14	PLUS APPEAL COST FROM LINE 5 \$	14	
		15	LESS REFUND FROM LINE 6 \$	15	
		16	AMOUNT TO USE FOR RATE CALCULATION \$	16	

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

KENWOOD HEALTHCARE CENTER

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0033589

CONTACT PERSON REGARDING THIS REPORT

Steven N. Lavenda

TELEPHONE (847) 236-1111

FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 20-14-408-017-0000	Long Term Care Property	\$ 1,236.58	\$ 1,236.58
2. 20-14-408-015-0000	Long Term Care Property	\$ 2,571.36	\$ 2,571.36
3. 20-14-409-005-0000	Long Term Care Property	\$ 304,364.46	\$ 304,364.46
4. 20-14-408-016-0000	Long Term Care Property	\$ 2,443.87	\$ 2,443.87
5. 20-14-409-004-0000	Long Term Care Property	\$ 101,340.80	\$ 101,340.80
6.		\$	\$
7. SW Management Allocation	Home Office Property	\$ 30,226.86	\$ 7,510.27
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 442,183.93	\$ 419,467.34

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

B. General Construction Type: ExteriorFrame

Number of Stories6

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES☐ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 9,781

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			1991	\$ 70,754	1
2			1997	265,000	2
3	TOTALS			\$ 335,754	3

XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1987		643		20	32	32	499	9
10	Various		1989		5,500		20	275	275	3,506	10
11	Various		1990		62,719		20	2,871	2,871	51,157	11
12	Various		1991		18,602		20	380	(380)	14,907	12
13	Various		1992		80,208		20	3,913	3,913	36,847	13
14	Various		1993		325,411		20	16,663	16,663	138,260	14
15	Various		1994		35,487		20	2,904	2,904	21,161	15
16	Various		1995		66,379		20	3,319	3,319	22,535	16
17	Various		1996		72,786		20	3,642	3,642	20,812	17
18	Various		1997		200,247		20	10,012	10,012	48,351	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

12/31/01

Facility Name & ID Number KENWOOD HEALTHCARE CENTER

0033589

Report Period Beginning:

01/01/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,304,551	\$ 463,472		\$ 200,053	\$ (263,419)	\$ 4,855,073	1
2	ELEVATOR-PUMP UNIT	1998	24,800		20	1,240	1,240	4,133	2
3	PAINTING & DECORATING	1998	9,556		20	478	478	1,434	3
4	WEATHER TEMP DAMPERS	1998	23,385		20	1,169	1,169	6,431	4
5	20 AMP CIRCUITS	1998	2,131		20	107	107	534	5
6	BLINDS	1998	5,596		20	280	280	1,540	6
7	CONCRETE COATING	1999	5,050		20	253	253	590	7
8	MASONRY	1999	15,135		20	757	757	1,829	8
9	HEATING COIL	1999	6,671		20	334	334	1,279	9
10	200 AMP BREAKER	1999	2,565		20	128	128	513	10
11	CHILLED WATER COIL	1999	7,515		20	376	376	1,003	11
12	CARPET	1999	1,600		20	80	80	227	12
13	CARPET	1999	3,285		20	164	164	575	13
14	AIR CONDITIONER	1999	10,544		20	527	527	1,405	14
15	225 AMP POLE BREAKER	1999	1,962		20	98	98	392	15
16	WALL GAURD	2000	1,498		20	75	75	119	16
17	ELEVATOR REPAIR	2000	1,800		20	90	90	158	17
18	WINDOW TREATMENT	2000	1,020		20	51	51	68	18
19	WALLPAPER	2000	883		20	44	44	77	19
20	WALLPAPER	2000	1,196		20	60	60	105	20
21	WALLPAPER	2000	1,470		20	74	74	130	21
22	WALLPAPER	2000	3,324		20	166	166	291	22
23	WALLPAPER	2000	21,712		20	1,086	1,086	1,901	23
24	WALLPAPER	2000	825		20	41	41	72	24
25	MINI BLINDS	2000	65		20	3	3	5	25
26	WALLPAPERS	2000	2,081		20	104	104	182	26
27	WALLPAPER	2000	4,663		20	233	233	408	27
28	WALLPAPER	2000	1,099		20	55	55	92	28
29	WALLPAPER	2000	3,146		20	157	157	262	29
30	WALLPAPER	2000	1,451		20	73	73	122	30
31	WALLPAPER	2000	826		20	41	41	68	31
32	WALLPAPER	2000	3,115		20	156	156	221	32
33	WINDOW TREATMENT	2000	18,430		20	922	922	1,306	33
34	TOTAL (lines 1 thru 33)		\$ 6,492,950	\$ 463,472		\$ 209,475	\$ (253,997)	\$ 4,882,545	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,492,950	\$ 463,472		\$ 209,475	\$ (253,997)	\$ 4,882,545	1
2	WALLPAPER INSTALL	2000	63,355		20	3,168	3,168	4,224	2
3	RADIATOR	2000	5,900		20	295	295	418	3
4	BOILERS	2000	4,514		20	226	226	320	4
5	DISHWASHER EXHAUST	2000	5,907		20	295	295	443	5
6	MECHANICAL EQUIPMENT	2001	7,255		20	545	545	545	6
7	ELECTRICAL BREAKERS	2001	9,294		20	697	697	697	7
8	SEWAGE PUMP	2001	8,495		20	496	496	496	8
9	STEAMER-GAS	2001	14,992		20	375	375	375	9
10	3 CIRCUIT BREAKER	2001	2,400		20	40	40	40	10
11	ELEVATOR	2001	84,968		20	1,416	1,416	1,416	11
12	WOOD DOORS	2001	5,867		20	489	489	489	12
13	CARPETING	2001	4,657		20	194	194	194	13
14	DOORS	2001	2,200		20	220	220	220	14
15	DOOR LOCKS	2001	1,115		20	56	56	56	15
16	DOOR HANDLES	2001	2,158		20	108	108	108	16
17	VALVE	2001	2,657		20	133	133	133	17
18	DOOR LOCKS	2001	1,261		20	63	63	63	18
19	DOOR LOCKS	2001	1,960		20	98	98	98	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,721,905	\$ 463,472		\$ 218,389	\$ (245,083)	\$ 4,892,880	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 6,721,905	\$ 463,472		\$ 218,389	\$ (245,083)	\$ 4,892,880	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,721,905	\$ 463,472		\$ 218,389	\$ (245,083)	\$ 4,892,880	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 6,721,905	\$ 463,472		\$ 218,389	\$ (245,083)	\$ 4,892,880	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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11									11
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,721,905	\$ 463,472		\$ 218,389	\$ (245,083)	\$ 4,892,880	34

**Improvement type must be detailed in order for the cost report to be considered complete.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 6,721,905	\$ 463,472		\$ 218,389	\$ (245,083)	\$ 4,892,880	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,721,905	\$ 463,472		\$ 218,389	\$ (245,083)	\$ 4,892,880	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 6,721,905	\$ 463,472		\$ 218,389	\$ (245,083)	\$ 4,892,880	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,721,905	\$ 463,472		\$ 218,389	\$ (245,083)	\$ 4,892,880	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 6,721,905	\$ 463,472		\$ 218,389	\$ (245,083)	\$ 4,892,880	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,721,905	\$ 463,472		\$ 218,389	\$ (245,083)	\$ 4,892,880	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 6,721,905	\$ 463,472		\$ 218,389	\$ (245,083)	\$ 4,892,880	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,721,905	\$ 463,472		\$ 218,389	\$ (245,083)	\$ 4,892,880	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1986		\$ 5,300,000	\$ 275,600	35	\$ 151,429	\$ (124,171)	\$ 4,468,735	4
5			1995		111,817	2,867	35	3,195	328	21,261	5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Allocation-SW Management	1995	\$ 11,900	\$ 614	20	\$ 710	\$ 96	\$ 4,568	37
38	Allocation-SW Management	1996	2,078	53	20	104	51	578	38
39	Allocation-SW Management	1997	2,993	161	20	215	54	913	39
40	Allocation-SW Management	1998	2,060	53	20	103	50	387	40
41	Allocation-SW Management	1999	5,721	147	20	286	139	596	41
42									42
43									43
44									44
45									45
46									46
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61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,436,569	\$ 279,495		\$ 156,042	\$ (123,453)	\$ 4,497,038	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 853,873	\$ 480	\$ 67,065	\$ 66,585	10	\$ 541,853	71
72	Current Year Purchases	69,221	1,325	4,053	2,728	10	4,053	72
73	Fully Depreciated Assets	665,164				10	665,164	73
74								74
75	TOTALS	\$ 1,588,258	\$ 1,805	\$ 71,118	\$ 69,313		\$ 1,211,070	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		FORD	1998	\$	\$	\$ 1,739	\$ 1,739		\$ 1,739	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$ 1,739	\$ 1,739		\$ 1,739	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,645,917	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 465,277	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 291,246	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (174,031)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,105,689	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ Description: (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	1998 Jaguar XJ8	\$ 1,135	\$ 13,620	17
18	Facility	2001 Lexus	564	3,384	18
19	SW Management Allocation			2,651	19
20					20
21	TOTAL		\$ 1,699	\$ 19,655	21

10. Effective dates of current rental agreement:

Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	\$
13.	/2003	\$
14.	/2004	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<div>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</div> <div><input type="checkbox"/> YES</div> <div><input checked="" type="checkbox"/> NO</div> <div>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</div>	2. <u>CLASSROOM PORTION:</u>		3. <u>CLINICAL PORTION:</u>	
	IN-HOUSE PROGRAM	<input type="checkbox"/>	IN-HOUSE PROGRAM	<input type="checkbox"/>
	IN OTHER FACILITY	<input type="checkbox"/>	IN OTHER FACILITY	<input type="checkbox"/>
	COMMUNITY COLLEGE	<input type="checkbox"/>	HOURS PER AIDE	<input type="text"/>
	HOURS PER AIDE	<input type="text"/>		

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	<input type="text"/>
2. From other facilities (f)	<input type="text"/>
DROP-OUTS	
1. From this facility	<input type="text"/>
2. From other facilities (f)	<input type="text"/>
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 30,038	\$		\$ 30,038	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			9,046			9,046	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			38,969			38,969	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				53,620		53,620	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):						17,645		17,645	13
14	TOTAL			\$		\$ 78,053	\$ 71,265		\$ 149,318	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 485,397	\$ 591,421	1
2	Cash-Patient Deposits	10,625	10,625	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,807,974	2,807,974	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	202,059	202,059	6
7	Other Prepaid Expenses	114,491	114,491	7
8	Accounts Receivable (owners or related parties)		78,000	8
9	Other(specify): See supplemental schedule	627,113	538,870	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,247,659	\$ 4,343,440	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	70,784	335,784	13
14	Buildings, at Historical Cost		5,300,000	14
15	Leasehold Improvements, at Historical Cost	837,171	847,688	15
16	Equipment, at Historical Cost	1,313,996	1,907,694	16
17	Accumulated Depreciation (book methods)	(1,291,958)	(6,360,243)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		88,031	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(22,008)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 929,993	\$ 2,096,946	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,177,652	\$ 6,440,386	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 413,444	\$ 415,690	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	32,455	32,455	28
29	Short-Term Notes Payable	200,000	200,000	29
30	Accrued Salaries Payable	188,598	188,598	30
31	Accrued Taxes Payable (excluding real estate taxes)	21,462	21,462	31
32	Accrued Real Estate Taxes(Sch.IX-B)	432,559	432,559	32
33	Accrued Interest Payable		25,258	33
34	Deferred Compensation			34
35	Federal and State Income Taxes		4,825	35
	Other Current Liabilities(specify):			
36	See supplemental schedule		46,965	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,288,518	\$ 1,367,812	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,418,621	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 3,418,621	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,288,518	\$ 4,786,433	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,889,134	\$ 1,653,953	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,177,652	\$ 6,440,386	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,228,204	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,228,204	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,204,930	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(2,544,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,339,070)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,889,134	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **KENWOOD HEALTHCARE CENTER**# **0033589**Report Period Beginning: **01/01/01**

Ending:

12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,991,679	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,991,679	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	65,133	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 65,133	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	75,650	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 75,650	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	44,320	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 44,320	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See supplemental schedule</u>	906	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 906	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,177,688	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,167,365	31
32	Health Care	2,354,963	32
33	General Administration	2,511,712	33
	B. Capital Expense		
34	Ownership	1,615,295	34
	C. Ancillary Expense		
35	Special Cost Centers	149,318	35
36	Provider Participation Fee	174,105	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,972,758	40
41	Income before Income Taxes (line 30 minus line 40)**	1,204,930	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,204,930	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number KENWOOD HEALTHCARE CENTER# 0033589

Report Period Beginning:

01/01/01

Ending:

12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,840	1,920	\$ 68,414	\$ 35.63	1
2	Assistant Director of Nursing	2,000	2,080	45,903	22.07	2
3	Registered Nurses	1,093	1,221	26,144	21.41	3
4	Licensed Practical Nurses	50,032	52,587	998,780	18.99	4
5	Nurse Aides & Orderlies	91,704	97,584	870,106	8.92	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,964	4,526	52,519	11.60	8
9	Activity Director					9
10	Activity Assistants	10,234	11,116	102,460	9.22	10
11	Social Service Workers	13,344	14,249	136,175	9.56	11
12	Dietician					12
13	Food Service Supervisor	7,965	8,309	116,744	14.05	13
14	Head Cook	4,427	4,839	37,615	7.77	14
15	Cook Helpers/Assistants	33,729	36,574	259,115	7.08	15
16	Dishwashers					16
17	Maintenance Workers	7,861	8,355	100,575	12.04	17
18	Housekeepers	50,377	52,854	379,369	7.18	18
19	Laundry	18,073	19,823	147,495	7.44	19
20	Administrator	1,960	2,080	85,354	41.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	47,046	50,992	771,208	15.12	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	345,649	369,109	\$ 4,197,976 *	\$ 11.37	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 5,141	01-03	35
36	Medical Director	Monthly	18,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,631	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	5	285	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	5	\$ 29,057		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount		Description	Amount
Ruth Gebert	Administrator	0%	\$ 85,354	Workers' Compensation Insurance	\$	72,705	IDPH License Fee	\$
				Unemployment Compensation Insurance		54,093	Advertising: Employee Recruitment	1,747
				FICA Taxes		321,107	Health Care Worker Background Check	
				Employee Health Insurance		40,578	(Indicate # of checks performed 126)	1,512
				Employee Meals			Inspections	894
				Illinois Municipal Retirement Fund (IMRF)*			Licenses/Fees/Permits	6,023
				Life Insurance		5,186	Dues & Subscriptions	5,796
				Miscellaneous Employee Benefits		27,508	SW Management Allocation	155
				Holiday Expense		578		
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)								
B. Administrative - Other								
Description			Amount					
Ronnie Klein - Management Fee			\$ 210,000				Less: Public Relations Expense	
SW Management-Management Fee			270,000				Non-allowable advertising	
							Yellow page advertising	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 480,000	TOTAL (agree to Schedule V,	\$	521,755	TOTAL (agree to Sch. V,	\$ 16,127
(Attach a copy of any management service agreement)				line 22, col.8)			line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Personnel Planners	Employment Consultant		\$ 1,830				Out-of-State Travel	\$
Frost, Ruttenberg & Rothhblatt	Accounting		15,680					
Ashman & Stein	Legal		84,778					
Allen Lefkovitz	Legal		19,010				In-State Travel	
David Fishman	Legal		8,915					
Metro Service	Legal		1,455					
Northwestern Medical Foundation	Legal		675					
Stone, Pogrund & Korey	Legal		10,494				Seminar Expense	2,600
Jeffrey Granich	Legal		20,000				SW Management Allocation	183
Winston & Strawn	Legal		320					
Notary Public Association	Legal		98					
SW Management	Home Office		234,000					
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			Entertainment Expense	
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 397,255				(agree to Sch. V,	
							line 24, col. 8)	\$ 2,783

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number KENWOOD HEALTHCARE CENTER		STATE OF ILLINOIS # 0033589	Report Period Beginning: 01/01/01	Ending: 12/31/01	Page 23
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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? Yes

(2) Are there any dues to nursing home associations included on the cost report? Yes
 If YES, give association name and amount. Illinois Council on Long Term Care-\$12,402.30

(3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
 What was the average life used for new equipment added during this period? 10

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line _____

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
 If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? _____ YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
KTNC Associates

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 174,105
 This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____

(16) Travel and Transportation
 a. Are there costs included for out-of-state travel? No
 If YES, attach a complete explanation.
 b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
 c. What percent of all travel expense relates to transportation of nurses and patients? 100% in 14
 d. Have vehicle usage logs been maintained? N/A
 e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
 f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

(17) Has an audit been performed by an independent certified public accounting firm? No
 Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes

(19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
 Attach invoices and a summary of services for all architect and appraisal fees